Treating Whiplash

General Preliminary Considerations[1]

by Darrell Sanchez, Ph.D., Certified Advanced Rolfer

Whiplash is one of our clients' most frequently presenting traumas and it is much more than a pain in the neck. Although cervical spine complaints are the most common among whiplash victims, thinking that whiplash is mostly about the neck would be wrong. It is true that the head and neck are the least secure masses thrown around by motor vehicle collisions. However, whiplash imparts intense forces to the whole body and brings chaos to the whole person. As a practitioner, have you ever asked yourself, "Why isn't my client getting better?" Or, "Why is this client still in pain and distress?" And even, "Why isn't my work effective?" If so, it is possible the client has suffered injuries requiring special considerations beyond the recipe or beyond the scope of structural integration altogether. At the same time, structural integration offers benefits to these clients that they are unlikely to get elsewhere. What follows is a brief description of common whiplash sequelae and a general guide to how to proceed when the client arrives following a whiplash event.

THE CONSEQUENCES OF WHIPLASH

In rear end collisions, the most common source of whiplash, one vehicle slams into another – which then slams into the victim. Muscle and sinew fibers snap back hard or snap altogether as bones are wrenched and shoved. Organs and internal structures strike protective bones and cavity walls. Body fluids crash against containing vessels. Whipsawing forces accelerate and decelerate along multiple vectors in milliseconds. Fasten you seat belt right now. Whiplash injuries include:

- Mild traumatic brain injury (MTBI)/ concussion
- Brain hemorrhages and subdural hematoma
- Rupture of anterior and posterior longitudinal ligaments and ligamentum flavum and disruption of transverse and alar ligaments
- Vertebral or occipital fracture, dislocation or subluxation
- Joint capsule or ligament damage
- Damage to the spinal cord or other nerve tissues
- Connective tissue scarring
- Disc avulsion
- Torn muscle fibers
- Neck muscle hemorrhages
- Injuries to the viscera, including organs, the esophagus, trachea, aorta and arterial vessels

Reported symptoms following whiplash include:

- Post-concussion headaches (PTSD headache syndrome)
- Post-traumatic stress
- Visual or auditory disturbances
- Confusion
- Balance problems
- Personality changes
- Thoracic outlet syndrome
- Muscle spasm
- Vertebral instability or abnormal motion restriction
- Reduced metabolic activity

These partial lists should enlighten both you and your client to the complexity and extent of rear-end collision damage *to the whole person*. In serious cases, the damage and disruption to the client's tissues are only the beginning. Imagine: the client was just sitting there obeying the traffic laws and minding his own business. Suddenly, without warning and through no fault of his own, the client suffers an injury the aftermath of which not only causes pain, but disrupts his sense of order and equilibrium at many levels. Fate seems to have dealt a cruel, undeserved and lasting blow to the entire order of the client's reality – and the client has to try to make sense of a universe in which such a thing could have happened. They also stand in stark contrast to the simplistically stated "pain in the neck" and "cervical sprain/strain" labels usually attached to them. No wonder these clients can be slow to improve! Often, even with a diverse team of caregivers, including both traditional and alternative disciplines, clients experience symptoms for one to five years or longer after an accident. But all is not gloom and doom for whiplash sufferers. They do improve and heal themselves some sooner than others, and structural integration – judiciously applied *in conjunction with other modalities appropriate to the client's specific symptoms and injuries* – can help.

PROPER INTAKE INFORMATION

For whiplash clients, I recommend an intake session before the first hands-on treatment. It is important to find out what your client is experiencing and what other practitioners he is seeing. Keep in mind that although you must gather certain information to treat your client as effectively as possible, an intake itself can be a delicate conversation. Chances are the client is still aroused and sensitive from the accident. He probably has recounted the story many times and not necessarily to the most receptive ears. Police on the scene can be helpful but might also have been inaccessible or downright hostile. Family and friends can be dismissive of the symptoms as being "all in your mind." Doctors and other health care providers can be overly rational or even condescending in their response to his complaints.

Four things you should learn are: what happened; what the symptoms and complaints are; what other resources are available; and whether this has happened before.

What happened? What time of day was it? Was it a rear end, broadside, head-on or oblique collision? Was it a rollover? What kind of vehicle struck the client's vehicle? How fast was the other vehicle going? Did the client's vehicle, in turn, strike anything else? Was the client wearing a seatbelt? What was the client doing at the time of impact? Was the client's head turned, or

was the client reaching for something at the time of impact? Did the client know the impact was coming? Did she hit her head, lose consciousness? Was anyone else in the client's car? Was the client's passenger or anyone in the other car seriously injured? What transpired immediately after the collision? How did the other driver behave? If the police showed up, how did the police officer behave? Were there witnesses? Was the client or any other injured person taken to the hospital? Find out as much as possible without stressing the client. Be receptive, and give the client plenty of room; better not to get every detail in one sitting than to re-traumatize the client in the initial intake.

What are the symptoms and complaints? What was the client's condition immediately after the collision, and what treatment did the client receive? What aches, pains and limitations does the client currently experience that were absent before the accident? Which ones were present before the accident but are worse now? How is the client's life different since the accident? What faculties or resources are lost, diminished or stressed? What are current or past diagnoses? Is the client currently taking medications?

At this point – especially if you want to address acute or recent injuries – it is critical to decide whether to advise the client to consult other health care providers. After all, we are obliged to do no harm, and always to act in the client's best interests. To properly advise the client, you need to know whether the client's symptoms indicate injuries beyond the scope of either structural integration in general or your own personal skills in particular. You must be able to recognize the symptoms of at least closed head injury; neurological or visceral damage or dysfunction; emotional problems associated with this injury or previous similar injuries; post-traumatic stress disorder, thoracic outlet syndrome; cranial-sacral dysfunction; facet fixation; vertebral damage; cognitive difficulties; and temporal-mandibular joint dysfunction. Chances are, your structural integration training did not necessarily equip you to recognize the symptoms of these conditions; if you accept whiplash clients, you should educate yourself in this regard.

What resources are available? Find out if the client has consulted, is consulting or has plans to consult with other health care practitioners. Consider possible referrals to practitioners whose expertise addresses more directly areas that structural integration does not – or you yourself cannot. How is the client coping with typical post-accident anxiety and depression? Are family and friends, doctors, lawyers and insurance agents sources of support or of stress? The idea is to identify resources, as social, cultural and familial relationships can help or hinder the healing process.

Has this happened before? Some people have suffered multiple whiplash accidents. Others have suffered multiple accidents to the same parts of their bodies. Still others have suffered multiple injuries from forces coming from a particular spatial vector. These injuries might have arisen from physical mishaps. However, they also might have arisen from physical, sexual or psychological trauma or abuse. In any such cases, the client might have a psychological, kinesthetic or perceptual distortion, blindness or dissociation with respect to a portion of the client's energetic field, or kinesphere.[2] This can be a sensitive topic: just having to admit to previous accidents can be disconcerting.

Do not judge or appear to judge the client; but do get a sense of whether (a) the client's recent injury re-traumatized prior injuries; or (b) the client was more vulnerable in the recent accident because of prior injuries. Are there other types of falls or accidents in the client's history? Do previous surgeries or hospitalizations relate to the current symptoms? How and by whom was the client treated for previous injuries, and what was the outcome? Any or all of these complicating factors can affect treatment protocols and outcomes.

A TEAM APPROACH

Because whiplash accidents can so profoundly affect every aspect of a person's reality, a team approach to the client's care is indicated. Modifying the belief that our, or any one, treatment modality alone is sufficient to cure all of a whiplash client's symptoms is usually in the client's best interest. To be most effective and to avoid complications, one must know as accurately as possible the actual injuries— the diagnosis or treatment of which might be well outside the scope of practice for structural integration. Clients may need diagnostic tests and medications or treatments that we can neither provide nor prescribe. Examples include accurate diagnosis and proper treatment of closed head injury, x-rays and MRIs, nutritional therapy, biofeedback, psychological counseling, neuropsychiatry and cognitive testing, and so forth.

In this connection, consider the possibility that structural integration might take an ancillary rather than primary role in the client's healing. For some of us, this might mean re-evaluating a core belief in the efficacy of structural integration to treat all ills. This belief is not in the client's best interests. To do what is best for your clients, it is advisable to have your own list of resources to whom you can refer them should they not have their own. If they do have their own, it is wise to coordinate with the client's other practitioners – especially chiropractors, osteopaths or acupuncturists – with and only with the client's express permission.

FORMULATING A STRATEGY

Structural integration can be an important and effective contribution to a whiplash client's healing; however, timing and approach is key. As for timing, the client might not be ready to manage a structural integration process. Some clients might have conditions – such as stroke, blood clotting or other vascular diseases – in the presence of which structural integration is contraindicated. Others with hypersensitive tissues, bone diseases or psychological disorders underlying or compounding the whiplash scenario might not be good candidates for structural integration. Structural integration has the potential to positively influence any injurious state. But, there are times when other treatment modalities might be more effective in directly addressing specific injuries or conditions, while supporting a faster recovery. If any of these pertain to your client, perhaps you should not treat the client at this time.

Should you decide to treat the client, it can be tempting to forego a normal structural integration process in favor of trying to fix the damage. However, a fix-it approach to whiplash tends to be frustrating, ineffective and counterproductive. In light of the potential depth, complexity and seriousness of the injuries, it can place too much expectation on both practitioner and client for the client to get better. In addition, we may think we are "fixing" one thing – say, a

hypertoned muscle – when in fact something else – perhaps a damaged nerve, blood vessel or joint capsule – is causing the tension and pain. What's more, a client's motivation to improve may be encumbered by a biochemically or functionally imbalanced mood state, making your efforts to "fix" anything futile. In addition, the idea of "fix-it" inherently suggests quickly healing or resolving a complaint. With whiplash, things happening too fast for the person to manage is precisely the cause of the injuries in the first place. Generally, it is better to take a slower third-paradigm approach instead.

Bringing a client through the fundamental grounding logic of the recipe can provide just the stabilizing and reassuring re-ordering of reality and experience the client needs. A car accident induces violent chaos: limbs flail, spines over-compress and over-extend, and organs and fluids get slammed around. If the client is ready, and other conditions are both known and addressed, an ordinary structural integration series has enormous value to the client's healing. On the other hand, if ever there is a case in which a rigidly applied recipe has its limits it is whiplash.

Seeing the recipe as a repository of the Principles and tailoring the work to the client's specific needs, might be just what is required. Remember that whiplash symptoms are long-lasting: ten or more sessions are not likely to resolve them completely. Within the framework of structural integration as a necessarily limited intervention we must be patient, as well as creative. Continual sensitivity and resiliency are useful approaches to whiplash. Our work needs to breathe and order needs to emerge without undue pressure. These are the very qualities that were lost or damaged in the accident. As practitioners, we ourselves must embody and manifest these qualities to evoke them in our clients.

PARTICULAR BENEFITS OF STRUCTURAL INTEGRATION FOR WHIPLASH

- A sense of grounding, support and stability
- Restored sense of strength and confidence to the client
- Decreased sense of dissociation in body and psyche
- Improved body awareness thus increasing a sense of empowerment and options
- Discharge of traumatic hyper-arousal and rebalance of autonomic nervous system function
- Aid in generating a sense of peace and well-being
- Stimulation of self-regulation and healing
- Enhanced general sense of resiliency in body and psyche
- Diminished postural compensations from the accident
- Greater sense of functional and psychological balance

Of course, structural integration will help undo the biomechanical damage of whiplash. But we offer far more than that. Fundamentally, structural integration re-establishes the client's sense of grounding, support and stability. Traumatic hyper-arousal is discharged, and autonomic nervous system function is normalized. With the client's sense of strength, confidence, and general personal resiliency restored, the client no longer dissociates, and self-regulation and healing become possible. In short, structural integration allows the client to bring order out of the whiplash-induced chaos.

CONCLUSION

Whiplash is more than a pain in the neck. It is a shattering experience for the whole person. Structural integration, as one component of a multi-disciplinary care plan, can help the client immensely. However, to work most effectively, the practitioner must take a careful history; have an accurate sense of the nature and extent of the client's injuries; and work in cooperation with practitioners able to address aspects of the client's condition outside the structural integration scope. Do what you do best and what you have been trained to do – and let others do the same.

© Darrell Sanchez, 2005

NOTES

1. This article is the first in a series concerning the treatment of whiplash through structural integration.

2. Laban, R., *The Mastery of Movement*, Plays, Inc., Boston, 1971. "The normal reach of our limbs, when they stretch away from our body without changing stance, determines the natural boundaries of the personal space or 'kinesphere' in which we move. This kinesphere remains constant in relation to the body even when we move away from the original stance; it travels with the body in the general space." (p. 38)

3. Bartenieff, I., and Lewis, D., *Body Movement: Coping with the Environment.* Gordon and Breach Science Publishers, New York, 1980. See description of kinesphere, icosahedron and A,B scales at pp. 24-43. Kinesphere is the "reach space" around a body, and is physically represented by the icosahedron. Kinesphere also relates to perceptual awareness relative to cardinal planes and axes, which are also physically demonstrated by the icosahedron. ❑